



Peripheral Vascular Disease Questionnaire

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M/F

Tobacco Usage: _____

Face Amount: _____

___Term 10 15 20 30

___UL

1. Date of first diagnosis: _____

2. What condition(s) have been diagnosed?

___Peripheral arterial disease ___Atherosclerosis ___ Peripheral Venous disorder

3. If diagnosed with Peripheral arterial disease, which of the following type?

___Carotid Artery Disease ___Peripheral Arterial Disease ___Abdominal aortic aneurysm
___Reynaud Syndrome ___Bueger Disease ___Polyarteris nodosa

4. If diagnosed with Peripheral venous disorders, which of the following type?

___Thrombophlebitis ___Varicose Veins ___Chronic venous insufficiency

5. Does the proposed insured have any of the following symptoms? (Check all that apply)

___Claudication ___Buttock Pain ___Numbness or tingling ___Change in skin color
___Impotence ___Infection/sores that do not heal

6. Has surgery been recommended or performed?

(If yes, please list dates and type of surgery)

7. Has the proposed insured ever been disabled because of the condition?

(If yes, please provide dates): _____

8. Is the proposed insured taking any medications? ___Yes ___No

(If yes, please provide name, dosage, and frequency)
